U.S. Department of Labor

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Issue Date: 13 July 2005

Case No. 2002-BLA-00205

In the Matter of

CHILION PROFFIT,
Claimant
v.

VALLEY CAMP COAL COMPANY
Employer,

ACORDIA EMPLOYERS SERVICE CORPORATION
Carrier,

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party In Interest

Appearances:
Christian Hartley, Esq., for Claimant
Mary Rich Malloy, Esq., for Employer

Before:
RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER GRANTING MODIFICATION

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. § 901, et seq. (hereinafter referred to as the Act). This case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs, for a formal hearing. Benefits are provided under the Act to a miner who is totally disabled due to pneumoconiosis and to certain survivors of a miner who died due to or while totally (or in certain cases, partially) disabled by pneumoconiosis. Pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

STATEMENT OF THE CASE

The decision in this matter is based upon a claim for benefits under the Act, filed by the Claimant on April 2, 1979. A notice of hearing was issued on April 29, 2004, and a formal hearing was conducted in Charleston, South Carolina, on August 12, 2004. The record on which this matter is considered consists of Director's exhibits 1 through 231 (DX 1-DX 231), which is the record submitted by the Director when the case was transmitted for hearing. At the hearing the Claimant submitted 5 exhibits, identified as CX 1-CX 5; the Employer submitted 13 exhibits, identified as EX 1-EX 13. All exhibits were admitted without objection. In addition to the exhibits, the Claimant testified at the August 12, 2004 hearing. The record was held open for submission of post hearing briefs. Both parties submitted briefs on November 15, 2004.

At the formal hearing the parties agreed (see the transcript at 5-6) that the April 2, 1979 claim is still pending, by way of timely appeals, requests for modification, et cetera. The case has been previously considered by three different Administrative Law Judges, with decisions being issued by those Judges. This matter has also been pending before the Benefits Review Board on multiple occasions. The last decision issued in this matter was by Judge John Holmes on October 24, 2000 (DX 214), and this matter is considered as a request for modification of that decision.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Because this matter involves a request for modification of a decision denying [modification of] the April 2, 1979 claim, the regulations at 20 C.F.R. Part 727 and 20 C.F.R. §725.310 apply. Further, since the parties stipulated to a finding that the Claimant worked in underground coal mining for at least 31 years (Tr. 11), the Claimant is entitled to consideration of his claim under the presumption of §727.203.

On October 24, 2000, Judge Holmes issued a Decision and Order Denying Modification. (DX 214). In that decision, Judge Holmes determined that the Claimant failed to establish that he had pneumoconiosis in order to establish a material change in condition, and also failed to prove a mistake of fact in the prior decision. Judge Holmes, accordingly, left intact Administrative Law Judge Edward T. Miller's 1996 determination that the Claimant failed to establish invocation under §§ 727.203(a)(1), (a)(2), (a)(3), or (a)(4), and that, if invocation were established, the Employer's evidence established (b)(3) and (b)(4) rebuttal. (DX 214, 155).

In its post-hearing brief, the Employer conceded that the Claimant has suffered a "material change in condition" since the most recent prior denial of his claim. Specifically, the Employer concedes that all of the medical evidence agrees that the Claimant developed a totally disabling pulmonary impairment around 2000 or 2001. Accordingly, I find that modification is appropriate and, on modification, the Part 727 regulations continue to apply. Further, the Employer has conceded that invocation of the presumption of §727.203 is now established with the evidence of the Claimant's totally disabling pulmonary impairment. (Employer's November 15, 2004 brief at 4).

Therefore, it is presumed that the Claimant is totally disabled due to pneumoconiosis arising out of coal mine employment. (§727.203(a)(4)). The medical evidence must now be weighed in order to determine whether the Employer has successfully rebutted the presumption pursuant to §727.203(b).

Subsection (b)(4) Rebuttal

As indicated above, the Employer concedes that Claimant suffers from a totally disabling respiratory impairment, and this is supported by all of the current physicians' opinions of record. Moreover, it is undisputed that Claimant has established more than ten years of coal mine employment as required at 20 C.F.R. § 727.203(a). As a result, he is entitled to a rebuttable presumption of total disability due to pneumoconiosis. 20 C.F.R. § 727.203(a).

Since Claimant has invoked the interim presumption, the burden shifts to Employer to establish rebuttal by a preponderance of the evidence. *Gilson v. Price River Coal Co.*, 6 B.L.R. 1-96 (1983). Clearly, the interim presumption cannot be rebutted under 20 C.F.R. §727.203(b)(1) or (b)(2). The Claimant is of advanced age, is not working, and the Employer has conceded that he is totally disabled.

Moreover, because Employer agrees that Claimant is totally disabled, it may establish rebuttal under either § 727.203(b)(3) (the miner's total disability did not arise in whole or in part out of coal miner employment) or § 727.203(b)(4) (the miner does not suffer from pneumoconiosis). 20 C.F.R. §§ 727.203(b)(3) and (b)(4).

Because rebuttal under subsection (b)(3) is dependent on whether the miner is (1) totally disabled, and (2) suffers from pneumoconiosis, it will be first determined whether the medical evidence is sufficient to establish that Claimant does not suffer from the disease under subsection (b)(4).

Under § 727.203(b)(4), Employer must present medical evidence sufficient to demonstrate the absence of any respiratory or pulmonary impairment arising out of coal dust exposure. *Biggs v. Consolidation Coal Co.*, 8 B.L.R. 1-317 (1985). Notably, the presumption may not be rebutted under subsection (b)(4) based solely on negative chest x-ray evidence. *Shonborn v. Director, OWCP*, 8 B.L.R. 1-434 (1986).

Summary of Chest X-Ray Evidence

When weighing chest x-ray evidence, the Board has held that it is proper to consider the qualifications of the physicians interpreting the chest X-rays.[1] In particular, it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a

[1] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:[2]

Exhibit #, Doctor, Qualifications	**Date of Film Date Read**	**Film Quality**	**Reading for Pneumoconiosis**
Dx. 33 Hayes unknown	06-09-75 06-09-75	Readable	--; "lungs are normal"; "no evidence of occupational pneumoconiosis"
Dx. 33 Hayes Unknown	03-12-79 03-12-79	Readable	--; "diffuse finely nodular fibrosis compatible with occupational pneumoconiosis"
Dx. 134 Wheeler B, BCR	03-12-79 11-10-94	2	Completely negative
Dx. 134 Scott B, BCR	03-12-79 11-10-94	2	Completely negative
Dx. 10 Saba unknown	07-28-79 09-18-79	Readable	Completely negative
Dx. 11 Rubenstein unknown	07-28-79 08-03-79	Readable	Completely negative
Dx. 15 Altman B, BCR	10-08-79 02-12-80	2	Completely negative
Dx. 15 Gaziano B	10-08-79 10-29-79	Readable	1/1
Dx. 16 Zaldivar B	09-23-80 09-23-80	Good	Completely negative
Dx. 18 Francke B, BCR	09-23-80 09-23-80	1	Completely negative
Dx. 208 Spitz B, BCR	09-23-80 02-16-00	2	Completely negative
Dx. 166 Wang unknown	09-23-80 04-11-97	2	Completely negative
Dx. 205 Wiot B, BCR	09-23-80 01-31-00	3	Completely negative
Dx. 208 Meyer B, BCR	09-23-80 03-07-00	2	--; "no evidence of coal workers' pneumoconiosis"
Dx. 19 Lee unknown	11-06-80 11-06-80	Readable	1/0
Dx. 27 Smith unknown	03-13-81 03-13-81	Readable	1/1

[2] A "--" under the Reading column of the chart indicates that the physician did not provide a specific category reading under the ILO-U/C classification system. 20 C.F.R. § 727.203(a)(1).

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
Dx. 34 Zaldivar B	03-13-81 06-06-82	Readable	Completely negative
Dx. 38 Francke B, BCR	03-13-81 12-10-82	1	0/0
Dx. 37 Srisumrid B	02-09-82 02-09-82	Readable	--; "essentially negative chest"; "no active lung disease"
Dx. 43 Pelaoz unknown	02-12-82 02-12-82	Readable	2/1
Dx. 38 Wiot B, BCR	02-12-82 12-08-82	2	0/0
Dx. 41 Proto B, BCR	02-12-82 12-15-82	2	0/0
Dx. 39 Spitz B, BCR	02-12-82 12-14-82	1	0/0
Dx. 46 Gale B	06-15-82 06-16-82	Readable	1/1
Dx. 41 Proto B, BCR	06-15-82 12-20-82	U/R	
Dx. 40 Spitz B, BCR	06-15-82 12-14-82	2	0/0
Dx. 102 Wiot B, BCR	11-21-83 06-12-93	1	Completely negative
Dx. 102 Shipley B, BCR	11-21-83 06-09-93	2	Completely negative
Dx. 106 Sargent B	11-21-83 08-01-93	1	--; "no evidence of coal workers' pneumoconiosis"
Dx. 102 Spitz B, BCR	11-21-83 06-16-93	1	Completely negative
Dx. 205 Wiot B, BCR	07-25-85 01-31-00	U/R	
Dx. 208 Meyer B, BCR	07-25-85 03-07-00	U/R	
Dx. 208 Spitz B, BCR	07-25-85 02-16-00	U/R	
Dx. 208 Meyer B, BCR	03-12-87 03-07-00	1	--; "no evidence of coal workers' pneumoconiosis"
Dx. 208 Spitz B, BCR	03-12-87 02-16-00	1	Completely negative
Dx. 205 Wiot B, BCR	03-12-87 01-31-00	1	--
Dx. 205 Wiot B, BCR	07-14-87 01-31-00	1	--
Dx. 208 Meyer B, BCR	07-14-87 08-07-00	1	--; "no evidence of coal workers' pneumoconiosis"

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
Dx. 208 Spitz B, BCR	07-14-87 02-16-00	1	Completely negative
Dx. 102 Wiot B, BCR	07-22-88 06-12-93	1	Completely negative
Dx. 103 Leef B, BCR	07-22-88 07-22-88	1	1/0
Dx. 102 Shipley B, BCR	07-22-88 06-09-93	2	Completely negative
Dx. 102 Spitz B, BCR	07-22-88 06-16-93	1	Completely negative
Dx. 78 Zaldivar B	07-22-88 12-21-88	1	Completely negative
Dx. 102 Spitz B, BCR	10-05-92 06-16-93	U/R	
Dx. 106 Sargent B	10-05-92 08-01-93	2	--; "no evidence of coal workers' pneumoconiosis"
Dx. 105, 125 Zaldivar B	10-05-92 07-07-93	3	Completely negative
Dx. 102 Wiot B, BCR	10-05-92 06-12-93	U/R	
Dx. 102 Shipley B, BCR	10-05-92 06-09-93	3	Completely negative
Dx. 103 Gaziano B	10-05-92 12-07-92	1	1/0
Dx. 110 Zaldivar B	08-25-93 09-27-93	1	0/1
Dx. 111 Wiot B, BCR	08-25-93 10-25-93	2	--; "no evidence of coal workers' pneumoconiosis"
Dx. 111 Spitz B, BCR	08-25-93 10-28-93	2	--; "no evidence of pneumoconiosis"
Dx. 112 Shipley B, BCR	08-25-93 11-10-93	2	--; "no coal workers' pneumoconiosis"
Dx. 117 Hayes B, BCR	11-19-93 11-20-93	readable	0/1
Dx. 116 Francke B, BCR	11-19-93 01-22-94	1	0/1
Dx. 132 Kim B, BCR	11-19-93 09-15-94	1	Completely negative
Dx. 132 Eisner B, BCR	11-19-93 09-20-94	1	--
Dx. 132 Scott B, BCR	11-19-93 09-07-94	1	Completely negative
Dx. 132 Wheeler	11-19-93	1	Completely negative

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
B, BCR	09-07-94		
Dx. 166 Wang unknown	12-16-94 04-11-97	2	1/0
Dx. 187 Wiot B, BCR	12-16-94 01-14-99	1	0/1
Dx. 190 Zaldivar B	12-16-94 03-14-94	1	0/1
Dx. 190 Spitz B, BCR	12-16-94 02-05-99	1	0/1
Dx. 192 Shipley B, BCR	12-16-94 05-18-99	2	--; "no coal workers' pneumoconiosis"
Dx. 221 Wiot B, BCR	03-29-95 06-08-01	1	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Dx. 174 Sargent B, BCR	03-29-95 07-03-98	1	--
Ex. 6 Wheeler B, BCR	03-29-95 08-28-02	2	--; "fibrosis"
Ex. 6 Scott B, BCR	03-29-95 08-27-02	1	--
Ex. 6 Scatarige B, BCR	03-29-95 08-27-02	1	--; "no evidence of coal workers' pneumoconiosis or silicosis"
Dx. 175 Sargent B, BCR	04-04-95 07-03-98	1	--
Dx. 176 Cole B, BCR	04-04-95 08-05-98	1	--
Dx. 221 Wiot B, BCR	04-04-95 06-08-01	2	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Ex. 6 Wheeler B, BCR	04-04-95 08-28-92	2	--
Ex. 6 Scott B, BCR	04-04-95 08-27-02	1	--
Ex. 6 Scatarige B, BCR	04-04-95 08-27-02	1	--
Dx. 166 Gaziano B	11-11-96 11-11-96	1	1/1
Dx. 166 Wang unknown	11-11-96 04-11-97	2	1/1
Dx. 190 Zaldivar B	11-11-96 03-14-94	1	0/1
Dx. 190 Spitz B, BCR	11-11-96 02-05-99	2	0/1
Dx. 192 Shipley	11-11-96	2	--; "no coal workers' pneumoconiosis"

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
B, BCR	05-18-99		
Dx. 195 Kim B, BCR	11-11-96 07-14-99	2	--
Dx. 195 Scott B, BCR	11-11-96 07-07-99	3	--; "no evidence of silicosis or coal workers' pneumoconiosis"
Dx. 195 Wheeler B, BCR	11-11-96 07-08-99	2	--
Dx. 187 Wiot B, BCR	11-11-96 01-14-99	3	0/1
Ex. 6 Wheeler B, BCR	09-21-97 08-28-02	2	--; "no silicosis or coal workers' pneumoconiosis"
Ex. 6 Scott B, BCR	09-21-97 08-27-02	2	--; "no evidence of silicosis or coal workers' pneumoconiosis"
Dx. 221 Wiot B, BCR	09-21-97 06-08-01	2	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Ex. 6 Scatarige B, BCR	09-21-97 08-27-02	2	--; "no evidence of coal workers' pneumoconiosis or silicosis"
Dx. 177 Sargent B, BCR	02-02-98 07-03-98	1	--; "not coal workers' pneumoconiosis"
Dx. 178 Cole B, BCR	02-02-98 08-05-98	2	--
Ex. 6 Wheeler B, BCR	02-02-98 08-28-02	2	--; "no silicosis or coal workers' pneumoconiosis"
Ex. 6 Scott B, BCR	02-02-98 08-27-02	1	--
Ex. 6 Scatarige B, BCR	02-02-98 08-27-02	1	--; "no evidence of coal workers' pneumoconiosis or silicosis"
Dx. 221 Wiot B, BCR	02-02-98 06-08-01	3	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Dx. 181 Conner unknown	02-02-98 02-02-98	readable	--; "The lungs are clear"; "normal chest"
Dx. 179 Cole B, BCR	03-29-98 08-05-98	2	--
Dx. 195 Perme B, BCR	09-16-98 07-06-99	1	--; "no radiographic evidence of coal workers' pneumoconiosis"
Dx. 197 Wheeler B, BCR	09-16-98 07-13-99	2	--; "no evidence of silicosis or coal workers' pneumoconiosis"
Dx. 197 Scott B, BCR	09-16-98 07-13-99	2	--; "no evidence of silicosis or coal workers' pneumoconiosis"
Dx. 198 Kim B, BCR	09-16-98 07-26-99	2	Completely negative
Dx. 182 Zaldivar	09-16-98	1	0/1

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
B	10-23-98		
Dx. 183 Wiot B, BCR	09-16-98 11-24-98	1	0/1
Dx. 185 Spitz B, BCR	09-16-98 11-25-98	1	0/1
Dx. 185 Shipley B, BCR	09-16-98 12-08-98	2	--; "no coal workers' pneumoconiosis"
Dx. 186 Patel B, BCR	11-17-98 12-14-98	1	1/0
Ex. 6 Wheeler B, BCR	11-17-98 08-28-02	1	--; "no silicosis or coal workers' pneumoconiosis"
Ex. 6 Scott B, BCR	11-17-98 08-27-02	1	--
Ex. 6 Scararige B, BCR	11-17-98 08-27-02	1	--; "no evidence of coal workers' pneumoconiosis or silicosis"
Dx. 221 Wiot B, BCR	11-17-98 06-08-01	3	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Ex. 6 Wheeler B, BCR	03-15-99 08-28-02	3	--; "no silicosis or coal workers' pneumoconiosis"
Ex. 6 Scott B, BCR	03-15-99 08-27-02	3	--
Ex. 6 Scatarige B, BCR	03-15-99 08-27-02	3	--
Dx. 221 Wiot B, BCR	03-15-99 06-08-01	2	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Dx. 229 Wiot B, BCR	07-19-00 05-18-00	U/R	
Cx. 1 Miller unknown	07-19-00 07-19-00	readable	--; "chronic bibasilar fibrosis consistent with the patient's known history of interstitial lung disease"
Ex. 7 Spitz B, BCR	07-19-00 09-23-02	U/R	
Ex. 9 Meyer B, BCR	07-19-00 11-05-02	U/R	
Cx. 1 Miller unknown	04-20-01 04-20-01	readable	--; "increased interstitial markings"; "chronic bibasilar fibrosis consistent with patient's known history of interstitial lung disease"
Dx. 221 Wiot B, BCR	04-02-01 06-08-01	1	--; "bibasilar interstitial fibrosis" but not due to coal dust exposure because not begin in the upper lungs
Ex. 6 Wheeler	04-02-01	2	--

Exhibit #, Doctor, Qualifications	Date of Film Date Read	Film Quality	Reading for Pneumoconiosis
B, BCR	08-28-02		
Ex. 6 Scott B, BCR	04-02-01 08-27-02	1	--
Ex. 6 Scatarige B, BCR	04-02-01 08-27-02	1	--; "no evidence of coal workers' pneumoconiosis or silicosis"
Ex. 1 Zaldivar B	03-13-02 06-11-02	2	Completely negative but, in a separate report, "increased fibrosis" was noted
Ex. 4 Wiot B, BCR	03-13-02 07-19-02	2	Completely negative
Ex. 4 Spitz B, BCR	03-13-02 08-02-02	2	Completely negative
Ex. 4 Meyer B, BCR	03-13-02 08-10-02	2	Completely negative
Ex. 8 Wheeler B, BCR	03-13-02 10-26-02	1	--
Ex. 8 Scott B, BCR	03-13-02 10-25-02	1	--
Ex. 8 Scatarige B, BCR	03-13-02 10-25-02	2	--; "no evidence of coal workers' pneumoconiosis or silicosis"; "cannot rule out minimal fibrosis"

Discussion and Conclusions Regarding Chest X-Ray Evidence

In this case, a preponderance of the chest x-ray interpretations are supportive of rebuttal under subsection (b)(4) on grounds that they do not demonstrate the presence of Category 1 pneumoconiosis or greater.

The studies dated June 1975 and March and July of 1979 did not yield findings of Category 1 pneumoconiosis or greater. Consequently, they do not support a finding of the disease.

The October 1979 study was interpreted as demonstrating Category 1 pneumoconiosis by a B-reader, but a dually-qualified physician concluded that the study was completely negative. Greater weight is accorded the interpretation of the dually-qualified physician such that this study does not support a finding of pneumoconiosis. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

A September 1980 study was interpreted as completely negative by a B-reader, four dually-qualified physicians, and a physician with unknown qualifications. There are no contrary readings of record and, as a result, this study does not support a finding of pneumoconiosis.

A November 1980 study was interpreted by a physician with unknown qualifications as demonstrating Category 1 pneumoconiosis. There are no contrary interpretations of this study such that it supports a finding of the disease.

The March 1981 study was interpreted as negative by a B-reader and a dually-qualified physician. A physician with unknown qualifications concluded that the study revealed Category 1 pneumoconiosis. It is proper to accord greater weight to the interpretations of the B-reader and dually-qualified physician over the interpretation of a physician with unknown qualifications. *Stanley v. Director, OWCP*, 7 B.L.R. 1-386 (1984). This study does not support a finding of pneumoconiosis.

A February 9, 1982 study was interpreted as negative by a B-reader. There are no contrary interpretations of this study and, consequently, it does not support a finding of pneumoconiosis.

A study conducted three days later, on February 12, 1982, yielded a Category 2 interpretation by a physician with unknown qualifications. Three dually-qualified physicians, on the other hand, concluded that the study was negative for the presence of pneumoconiosis. Greater weight is accorded the findings of the dually-qualified physicians over the interpretation of a physician whose qualifications are unknown. *See Stanley, supra*. Therefore, this study does not support a finding of pneumoconiosis.

The June 1982 study was found "unreadable" by one dually-qualified physician. One B-reader concluded that the study demonstrates Category 1 pneumoconiosis, but another dually-qualified physician concluded that the x-ray was completely negative. Given the highly inconsistent interpretations of this study, it is not probative of a finding of pneumoconiosis particularly in light of the fact that dually-qualified physicians concluded that the study was either unreadable or completely negative.

A November 1983 study was interpreted as negative by three dually-qualified physicians and one B-reader. There are no contrary interpretations such that the study does not support a finding of pneumoconiosis.

A July 1985 study was found unreadable by three dually-qualified physicians. Therefore, this study is not probative of the presence or absence of pneumoconiosis.

The March and July 1987 studies were interpreted as negative by three dually-qualified physicians. There are no contrary readings of these studies and, consequently, they do not support a finding of the disease.

A study conducted a year later, on July 22, 1988, was interpreted as negative by four dually-qualified physicians and a B-reader. There are no contrary readings of this study and it does not support a finding of pneumoconiosis.

The October 1992 study was interpreted as negative for the presence of pneumoconiosis by one dually-qualified physician and a B-reader. Two dually-qualified physicians concluded that the study was unreadable. One B-reader determined that the study revealed Category 1 pneumoconiosis. On balance, all of the dually-qualified physicians who reviewed the study concluded that it was either negative or unreadable. Consequently, this study is not probative of a finding of pneumoconiosis.

An August 1993 study was interpreted as negative for the presence of pneumoconiosis by one B-reader and three dually-qualified physicians. There are no contrary interpretations of this study such that it does not support a finding of the disease.

Similarly, the November 1993 study was interpreted as negative by six dually-qualified physicians. There are no contrary readings and, consequently, the study does not support a finding of pneumoconiosis.

A December 1994 study was interpreted as demonstrating Category 1 pneumoconiosis by a physician with unknown radiological qualifications. On the other hand, three dually-qualified physicians and a B-reader concluded that the study was negative. Greater weight is accorded the negative findings of the dually-qualified physicians and B-reader over the interpretation of a physician with unknown qualifications. *See Stanley, supra*. Consequently, this study does not support a finding of pneumoconiosis.

The March and April 1995 studies produced negative interpretations by various dually-qualified physicians. There are no contrary interpretations of the studies such that they do not support a finding of the disease.

A November 1996 study was interpreted as positive for the presence of pneumoconiosis by a physician with unknown qualifications and a B-reader. Six dually-qualified physicians and a B-reader concluded that the study did not reveal the presence of the disease. Given the superior qualifications of the dually-qualified physicians and their consistently negative interpretations, it is determined that this study does not support a finding of pneumoconiosis.

The September 1997 and February and September 1998 studies yielded numerous negative interpretations by various dually-qualified physicians and B-readers. There are no contrary interpretations of these studies such that they do not support a finding of pneumoconiosis.

One dually-qualified physician concluded that the November 1998 study supported a finding of Category 1 pneumoconiosis. However, this interpretation is outweighed by the negative findings of four other dually-qualified physicians. On balance, this study does not support a finding of pneumoconiosis.

All of the remaining studies of record, dated March 1999, July 2000, April 2001, and March 2002, did not produce positive interpretations by any of the dually-qualified physicians or B-readers interpreting the studies. Consequently, these recent studies do not support a finding of pneumoconiosis.

In sum, the chest x-ray studies span nearly 30 years. Only the November 1980 study yielded a positive interpretation by a physician with unknown qualifications and there were no contrary readings of the study. All of the prior and subsequent studies were interpreted by dually-qualified physicians, who have superior radiological qualifications, as either unreadable or not supportive of a finding of Category 1 pneumoconiosis or greater. Therefore, on balance, the chest x-ray studies do not support a finding that Claimant suffers from pneumoconiosis.

Summary of Medical Opinion Evidence

Preponderantly negative chest x-ray evidence, standing alone, is not sufficient to establish subsection (b)(4) rebuttal. *Edwards v. Central Coal Co.*, 7 B.L.R. 1-712 (1985); *Conley v. Roberts and Shaefer Co.*, 7 B.L.R. 1-309 (1984). The medical opinion evidence must also be considered in determining whether the interim presumption is rebutted under this subsection. Specifically, Employer carries the burden of demonstrating through well-reasoned, well-documented medical opinion evidence that the miner does not suffer from coal workers' pneumoconiosis.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

Upon review of the physicians' opinions, there is agreement that recent objective medical data demonstrates the presence of a progressive, disabling interstitial fibrosis. The cause of the interstitial or pulmonary fibrosis is disputed. Drs. Crisalli, Zaldivar, Loudon, Fino, and Spagnolo conclude that the miner suffers from, *inter alia*, idiopathic pulmonary fibrosis. Dr. Frank, on the other hand, concludes that the fibrosis developing in the miner's lungs is due to his coal dust exposure. Drs. Jones, Hayes, Gaziano, Egnor, Puskin, Rasmussen, Walker, Miller, and Kennedy also conclude that the miner suffers from coal dust induced respiratory impairment. The

following medical reports were admitted as evidence in the record:

The West Virginia Occupational Pneumoconiosis Board.

In support of a determination of the West Virginia Occupational Pneumoconiosis Board (WVP Board), Drs. Ralph Jones and W.G. Hayes issued a report on June 9, 1975, wherein they noted that the miner's breath sounds were unimpaired and heart sounds were "unremarkable." They found that Claimant exhibited hyperventilation with exercise. Drs. Jones and Hayes rendered a "diagnosis of occupational pneumoconiosis with 15% impairment" on behalf of the WVP Board.

On January 24, 1977, the WVP Board ("WV Board") issued a determination. *Dx.* 3. In this determination, the WVP Board noted that Claimant had worked in the mines for 31 years and had suffered from shortness of breath for ten years. The WVP Board further noted that the miner complained of wheezing, bilateral chest pain, and chronic cough with sputum production. Examination of the chest revealed suppressed breath sounds. A chest x-ray demonstrated "some increased peri-bronchial markings bilaterally." The WVP Board stated that the miner was unable to undergo an exercise tolerance test due to angina pectoris. It concluded that Claimant suffered from coal workers' pneumoconiosis and had a 15 percent disability.

In a second report dated March 12, 1979, Drs. Jones and Hayes continued to find that the miner's breath sounds were "unimpaired" and his "heart sounds (were) of fair quality." They concluded that the miner suffered from occupational pneumoconiosis, but that he did not suffer an "impairment of capacity for work therefrom." *Dx.* 33.

Dr. Martin Fritzhand.

On July 28, 1979, Dr. Martin Fritzhand examined and tested the miner on behalf of the Department of Labor. *Dx.* 8. In his report, Dr. Fritzhand noted a 30 to 40 year history of smoking one-half a pack of cigarettes per day as well as 31 years of coal mine employment. He stated that a tuberculosis test conducted in 1974 yielded negative results. Dr. Fritzhand noted that the miner complained of shortness of breath for ten years, but denied a history of chronic cough. He further stated that Claimant "notes intermittent episodes of sharp generalized pain occurring two-three times daily" and the "chest pain is not related to exercise." Examination of the chest revealed a normal A/P diameter and the miner had clear breath sounds with no "rales, rhonchi, or wheezes." Dr. Fritzhand noted that Claimant did not use "accessory muscles of respiration." He further found that the miner's "heart rate (was) regular without a murmur, gallop or irregularity."

In a supplemental letter dated April 29, 1982, Dr. Fritzhand noted that the chest x-ray conducted during his July 1979 examination "was completely normal and there was no evidence of coal workers' pneumoconiosis." He opined that abnormalities on the miner's pulmonary function and blood gas testing were due to his history of smoking. Dr. Fritzhand concluded that

"[a]s the patient did not have evidence of pneumoconiosis, I do not feel that he was totally disabled from performing his former coal mine work."

Dr. Fritzhand subsequently reviewed certain additional medical records, including Dr. Crisalli's 1988 report. He expressed agreement with Dr. Crisalli that Claimant did not suffer from coal workers' pneumoconiosis and had no significant pulmonary dysfunction. Without explanation, Dr. Fritzhand also concluded that the miner was not totally disabled as a whole man.

Dr. Fritzhand is board-certified in internal medicine.

Dr. Dominic Gaziano.

Dr. Dominic Gaziano served as one of Claimant's treating physicians. By letter dated July 17, 1980, Dr. Gaziano concluded that the miner had been unable to work since 1977 due to "many symptoms." *Dx.* 30. In particular, Dr. Gaziano noted that Claimant was "intensely anxious and nervous and ha[d] a number of symptoms of anxiety which include[d] shortness of breath, palpitations, dysphesis, severe weakness, dizziness, and headache." He also stated that the miner suffers from "severe substernal chest pain" despite normal EKG results. Dr. Gaziano diagnosed Claimant with coal workers' pneumoconiosis and hypertension and he concluded that the miner was disabled "by virtue of his advanced age and his many symptoms."

By letter dated October 24, 1992, Dr. Gaziano stated that the miner was seen in his office on October 5, 1992 at which time he continued "to complain of shortness of breath." *Dx*. 104. Examination of the lungs revealed rales "over both lung fields." A chest x-ray was interpreted as demonstrating Category 1 pneumoconiosis. The miner's pulmonary function testing produced normal results, but "his diffusing capacity was 67% of predicted, indicating a moderate degree of pulmonary functional impairment." Dr. Gaziano explained that "[t]he presence of rales and the reduced diffusing capacity confirm the presence of an occupational pneumoconiosis." He concluded that the miner was totally disabled from his last job as a general laborer, which required heavy manual labor.

By letter dated November 9, 1993, Dr. Gaziano noted that Claimant had been one of his patients since 1975 and that he suffered from coal workers' pneumoconiosis and diabetes mellitus. *Dx.* 119. Dr. Gaziano noted that Claimant's "most recent pulmonary function test shows a moderate degree of pulmonary functional impairment, particularly as reflected by the diffusing capacity."

On October 24, 1994, Dr. Gaziano issued a letter stating that the miner was seen in his office "again" complaining of shortness of breath and "very little cough." Examination of the lungs revealed "rales in both bases which did not clear with cough." Dr. Gaziano noted that prior chest x-rays had demonstrated the presence of occupational pneumoconiosis and, although ventilatory testing produced normal values, they revealed a "mild reduction in diffusing capacity" and the "residual volume was reduced." Dr. Gaziano reiterated that the miner suffered from coal workers' pneumoconiosis and was disabled from a respiratory standpoint from performing his last coal mine work requiring heavy labor.

Dr. Gaziano is board-certified in internal medicine and chest diseases. He is also a B-reader.

Dr. James K. Egnor II.

Dr. James K. Egnor II examined and tested the miner and issued a report on May 22, 1981. *Dx.* 27. He reported 31 years of coal mine employment and a 15 to 20 pack year smoking history. Dr. Egnor noted that the miner received disability payments from the Social Security Administration due to his angina and hypertension. He stated that the miner's "most limiting factor is angina." Dr. Egnor stated that the miner complained of occasional wheezing daily as well as a daily productive cough. Physical examination revealed that the miner was obese. His chest was "clear" and AP diameter was normal. Dr. Egnor did not hear wheezing on forced expiration and heart sounds were regular. A chest x-ray demonstrated Category 1 pneumoconiosis. Pulmonary function testing did not yield reproducible results, but the results were within normal limits. Blood gas testing demonstrated normal values. Dr. Egnor concluded that there was sufficient data to justify a diagnosis of coal workers' pneumoconiosis, but there was no measurable pulmonary disability. He stated that the miner was "disabled due to angina."

Dr. Egnor is board-certified in internal medicine.

Dr. Willard Puskin.

Dr. Willard Puskin reviewed certain medical records and issued a report on June 19, 1982. *Dx.* 36. He noted that records underlying the determination of the WVP Board supported a finding of occupational pneumoconiosis. Dr. Puskin further found that pulmonary function testing revealed a mild to moderate obstructive impairment. He stated the following with regard to exercise testing conducted on June 21, 1977:

> It was the feeling of the cardiologist that (Claimant's) chest pains were of non-cardiac origin, however, subsequent events indicated that he did eventually suffer from coronary insufficiency and angina pectoris.

Dr. Puskin concluded that the miner was not totally disabled from a pulmonary standpoint, but Claimant's "age, together with the history of angina pectoris would definitely contraindicate continuation in this type of work."

Dr. Puskin's qualifications are not in the record.

Dr. D.L. Rasmussen.

Dr. D.L. Rasmussen examined and tested the miner and issued a report on July 25, 1985. *Dx.* 53. He noted a 32 year history of coal mine employment, where Claimant last worked in

1979, as well as a 20 year history of smoking one-half a pack of cigarettes per day. Examination of the lungs revealed normal breath sounds with no rales, rhonchi, or wheezes. Heart tones were also normal "with regular rhythm and no murmurs." Ventilatory testing produced normal values and blood gas testing also produced normal values at rest. However, Dr. Rasmussen noted that, after exercise, the miner's EKG and blood pressure responses were normal, but his "[g]as exchange was moderately impaired, and the patient was moderately hypoxic." He stated that Claimant never reached his anaerobic threshold. Dr. Rasmussen concluded that the studies indicated a "moderate to moderately severe impairment in respiratory functional capacity." As a result, Dr. Rasmussen opined that the miner was totally disabled due to a respiratory impairment. He did not, however, specify the cause of the respiratory impairment.

More than nine years later, Dr. Rasmussen examined and tested the miner again and issued a report on November 30, 1994. *Dx.* 135. He reported 32 years of coal mine employment involving "considerable and some very heavy manual labor" shoveling and shooting slate as well as rock dusting where Claimant "broke rock with sledge hammers." Dr. Rasmussen further noted that the miner smoked one-half a pack of cigarettes per day from the age of 15 years in 1934 until he quit in 1975. Examination of the lungs revealed breath sounds that were "minimally to moderately reduced" as well as a "few bilateral bibasilar rales." The miner's heart tones were normal without murmurs, gallops, or clicks. Ventilatory and blood gas testing produced normal results. The single breath carbon monoxide diffusing capacity test yielded minimally reduced values. The miner experienced "left upper chest discomfort" on exercise, his oxygen transfer was "markedly impaired," and Claimant was "moderately hypoxic." Dr. Rasmussen concluded the following:

> These studies, overall, indicate moderately severe loss of respiratory function as reflected by the minimal reduced diffusing capacity and the moderate to marked impairment in oxygen transfer during light to moderate exercise.

As a result, Dr. Rasmussen concluded that Claimant was totally disabled from performing his last coal mining job. Moreover, Dr. Rasmussen stated that the test results were consistent with a diagnosis of coal workers' pneumoconiosis and the impairment could be attributed to Claimant's "many years of coal mine dust exposure."

Dr. Rasmussen is board-certified in internal medicine and pulmonary diseases. He is also a B-reader. He serves as the Director of the Appalachian Pulmonary Laboratory and has served on a variety of federally-sponsored committees and task forces on coal mine health. Dr. Rasmussen has also been asked to testify before Congress on issues of coal workers' lung diseases. In 1969, he received the American Public Health Association Presidential Award for exceptional service in black lung. He has also been a contributing author of numerous publications related to occupational and pulmonary diseases, including coal workers' pneumoconiosis.

Dr. Robert J. Crisalli.

Dr. Robert J. Crisalli examined and tested the miner and issued a report on August 23, 1988. *Dx.* 75. He noted 32 years of coal mine employment as well as a "moderate to heavy smoking history." Examination of the miner revealed "no evidence of pulmonary disease or pulmonary related cardiac disease." Pulmonary function testing and resting blood gas testing yielded normal values. Dr. Crisalli noted that an exercise blood gas test was not conducted because Claimant's "left knee was swollen." He diagnosed the miner as suffering from chronic bronchitis of 10 to 12 years duration and that the miner was overweight. A review of certain other medical records demonstrated preponderantly negative chest x-ray findings. Dr. Crisalli concluded that there was insufficient medical data to justify a diagnosis of coal workers' pneumoconiosis and that the miner suffered from "no significant pulmonary dysfunction."

By supplemental report dated November 3, 1994, Dr. Crisalli reviewed certain medical records. *Dx.* 133. He reiterated that Claimant did not suffer from coal workers' pneumoconiosis or any chronic dust disease of the lung related to coal dust exposure. Dr. Crisalli found that the miner exhibited no impairment on pulmonary function testing. He concluded that Claimant did not suffer from any disability related to coal dust exposure and he was not disabled as a whole man.

Dr. Crisalli conducted a second examination of the miner on March 29, 1995, reviewed certain additional medical records, and issued a report on April 18, 1995. *Dx.* 144. He noted 32 years of coal mine employment, where Claimant worked as a general laborer. Dr. Crisalli further noted that the miner smoked one-half a pack of cigarettes per day from the age of 15 years until he quit in 1975. Examination of the lungs revealed a "few minimal bibasilar rales" during the inspiratory phase. The cardiovascular examination yielded normal findings. Ventilatory and resting blood gas testing produced normal values. Dr. Crisalli noted that Claimant could not undergo exercise testing due to knee problems. He diagnosed chronic bronchitis based on the miner's history of cough and sputum production, which occurred "daily for several years." Dr. Crisalli also opined that Claimant suffered from obesity, hypertension, and non-insulin dependent diabetes mellitus. He stated that a chest x-ray conducted in conjunction with the examination was not of good quality and had to be redone. Dr. Crisalli concluded that there was no change in his opinion since his August 23, 1988 and November 3, 1994 reports–the miner did not suffer from clinical or legal coal workers' pneumoconiosis.

Dr. Crisalli was deposed on April 19, 1995. *Dx.* 143. During his deposition, he reiterated the findings and diagnoses from his medical opinions. He also noted that "[t]obacco smoke exposure can cause changes which result in chronic bronchitis, which is a disease of cough and sputum production, and it can cause changes of emphysema." *Dx.* 143 at 11. Dr. Crisalli maintained that, from a respiratory standpoint, Claimant had the ability to perform his last coal mining work, which required arduous manual labor. *Dx.* 143 at 15. However, he concluded that Claimant was totally disabled as a "whole man" due to his "joint disease." *Dx.* 143 at 16. During a subsequent deposition on July 19, 2000, Dr. Crisalli reiterated that the miner did not suffer from coal workers' pneumoconiosis and he did not have a respiratory or pulmonary disability. *Dx.* 212.

Dr. Crisalli reviewed certain medical records and issued a report on August 21, 2002. *Ex.* 5. He stated that the miner did not suffer from clinical or legal coal workers' pneumoconiosis, but concluded the following:

> Mr. Proffitt now has a significant respiratory impairment. None of this impairment is related to coal dust exposure or to coal workers' pneumoconiosis based on the radiographic studies and his resolution CT-scan appearance of the abnormalities, and based on the appearance of the disease so many years after Mr. Proffitt stopped work in the coal mines.

At this point, Dr. Crisalli concluded that the miner's age and respiratory impairment rendered him totally disabled. Moreover, he stated that the miner's respiratory impairment is related to "pulmonary fibrosis which is unrelated to coal dust exposure."

Dr. Crisalli again reviewed certain medical records and issued a supplemental opinion on March 16, 2004. *Ex.* 10. He concludes that there is insufficient medical data to justify a diagnosis of clinical or legal coal workers' pneumoconiosis. Again, he opined that Claimant has a "significant respiratory impairment which is secondary to the development of pulmonary fibrosis and bronchiectasis" unrelated to coal dust exposure. He stated that the miner is totally disabled due to the respiratory impairment.

Dr. Crisalli was deposed for a third time in conjunction with this claim on August 9, 2004. *Ex.* 13. He testified that:

> Mr. Proffitt had a significant respiratory impairment. This impairment was related to a pulmonary fibrotic process which was unrelated to his coal dust exposure and also to the associated bronchiectasis, also not related to coal dust exposure.

Ex. 13 at 8-9. This impairment has left Claimant totally disabled. *Ex.* 13 at 9.

Dr. Crisalli notes that a restrictive impairment has developed in recent testing and that the miner began to develop a "pulmonary fibrotic process" around 2000 or 2001. *Ex.* 13 at 10 and 12. Dr. Crisalli sets forth four reasons why the pulmonary fibrosis is unrelated to coal dust exposure in this case: (1) the chest x-rays and CT-scan demonstrate an interstitial process, which is not a process that one would expect with coal workers' pneumoconiosis; (2) the "honeycombing pattern" seen on the chest x-ray or CT-scan is not typical of coal workers' pneumoconiosis; (3) there is no mention of nodules on the CT-scan, except for some subpleural nodules located in areas that are atypical of coal workers' pneumoconiosis; and (4) the fibrosis is located mostly in the lower lung, which is not typical of coal workers' pneumoconiosis. *Ex.* 13 at 13. He noted that the "honeycombing" in the miner's lungs was caused by "fibrosing disease of the lungs." *Ex.* 13 at 77. Dr. Crisalli testified that the cause of Claimant's pulmonary fibrosis is unknown. *Ex.* 13 at 15.

Dr. Crisalli testified that he was shown a video of Claimant and noted that the miner appeared to have "had some difficulty getting out his sentences without taking extra breaths . . .." *Ex.* 13 at 34. He stated, however, that it would constitute "bad medicine" to attribute the miner's symptoms to a coal dust induced lung disease:

> The reason that would be bad medicine is that Mr. Proffitt stopped working in the coal mines around 1979, I believe. So by 1995, we had sixteen years that went along. And my knowledge of his pulmonary functions are that they were normal.
>
> And he starts to have this process in the lungs, and it would be inappropriate just to write this off as pneumoconiosis.

Ex. 13 at 40. Dr. Crisalli opined that "[t]here isn't a latent period for coal workers' pneumoconiosis like there is for asbestosis." *Ex.* 13 at 92.

Dr. Crisalli stated that he would "rule out" pneumoconiosis as the cause of Claimant's pulmonary disability, even if it was assumed that the disease was present:

> The reason it does not fit this process is because we have the absence of an obstructive impairment which is the most common presentation of coal workers' pneumoconiosis. This isn't to say that pneumoconiosis cannot cause a restrictive impairment.
>
> But if coal workers' pneumoconiosis is going to cause a restrictive impairment, I would expect to see some obstructive impairment along with it.
>
> The absence of that obstructive impairment in this case causes me to say that pneumoconiosis is not the diagnosis, that this is one of the factors. It is not the diagnosis.

Ex. 13 at 43-44.

Dr. Crisalli acknowledged that coal workers' pneumoconiosis can cause either a restrictive or obstructive impairment, or both. *Ex.* 13 at 63. He further stated that the miner's productive cough was consistent with bronchitis caused by coal dust exposure and cigarette smoking. *Ex.* 13 at 64-65. He reiterated that the miner suffered from "idiopathic" pulmonary fibrosis, which means that the cause of the fibrosis is unknown. *Ex.* 13 at 85.

Dr. Crisalli is board-certified in internal medicine and pulmonary diseases. He serves as a Clinical Associate Professor of Medicine at the West Virginia University School of Medicine. He is also the Chief of the Pulmonary Subsection and Medical Director of the Intensive Care Unit at the Charleston Area Medical Center in Charleston, West Virginia. He states that "[a] large number of (his) patients are coal miners, former coal miners, and a large number of them have coal workers' pneumoconiosis." *Ex.* 13 at 4.

Dr. George Zaldivar.

Dr. George Zaldivar reviewed certain medical records and issued a report on December 26, 1988. *Dx.* 78. He concluded that the miner did not suffer from coal workers' pneumoconiosis and noted that ventilatory and blood gas testing produced normal values, except for Dr. Rasmussen's exercise testing. Dr. Zaldivar concluded that Claimant did not suffer from a pulmonary impairment.

Dr. Zaldivar examined and tested the miner on August 25, 1993, reviewed certain medical records, and issued a report on October 7, 1993. *Dx.* 110. He noted that Claimant's chief complaint was shortness of breath. Dr. Zaldivar reported that Claimant worked in the coal mines for 32 years, quitting in 1979, and Claimant quit smoking in 1975. He further reported no history of asthma or emphysema and no history of heart disease. On examination, the lungs were clear, without wheezes, crackles, or rales. Dr. Zaldivar noted the following with regard to the extent of the miner's impairment:

> He does have a mild diffusion impairment but he also has smaller than average total lung capacity. When corrected for this total lung capacity, his diffusing capacity is normal.

Importantly, Dr. Zaldivar, in a later report, admits that the Department of Labor does not recognize differing pulmonary function values based on a person's race. In his 1993 report, Dr. Zaldivar concluded that Claimant did not suffer from coal workers' pneumoconiosis and did not suffer from a pulmonary disability. He did find that the miner was totally disabled due to his age and deconditioning.

Dr. Zaldivar reviewed certain additional medical records and issued a supplemental report on November 3, 1994. *Dx.* 133. He continued to conclude that the miner did not suffer from clinical or legal coal workers' pneumoconiosis. He also found that Claimant did not have a pulmonary impairment. Even assuming that the miner did suffer from coal workers' pneumoconiosis, Dr. Zaldivar opined that Claimant's disability would not be related to such coal dust exposure.

Dr. Zaldivar was deposed on May 3, 1995. *Dx.* 148. He noted that the miner's last coal mining work would, at times, involve very heavy manual labor. *Dx.* 148 at 35. However, Dr. Zaldivar opined that "[a]ll previous testing of Mr. Proffitt show that is breathing capacity allows him to do arduous manual labor, if necessary." *Dx.* 148 at 35. He concluded that the miner was totally disabled based on his age. *Dx.* 148 at 37. There was no evidence of coal workers' pneumoconiosis or any pulmonary abnormality related to coal dust exposure. *Dx.* 148 at 37.

Dr. Zaldivar examined and tested the miner, reviewed certain medical records, and issued a report on October 26, 1998. *Dx.* 182. Examination of the heart revealed no murmurs or gallops. The lungs were "clear to auscultation without wheezes, crackles, or rales. Blood gas testing at rest produced normal values. The miner had a low carboxyhemoglobin level consistent with that of a current non-smoker. There were no x-ray findings to suggest the presence of

pneumoconiosis. Dr. Zaldivar concluded that there was no objective evidence to justify a diagnosis of coal workers' pneumoconiosis or the "presence of any pulmonary impairment." He stated that Claimant retains the pulmonary capacity sufficient to perform heavy manual labor, but that he is totally disabled due to his advanced age of 79 years.

Dr. Zaldivar examined and tested the miner on March 13, 2002, reviewed certain medical records, and issued a report on June 20, 2002. *Ex.* 1. He stated the following with regard to the miner's condition:

> [There is] no radiographic evidence of pneumoconiosis. There are increased linear and nodular markings in the mid and lower lung zones which obscure the heart to a small extent. These findings are compatible with either poor inspiratory effort or pulmonary fibrosis.

Dr. Zaldivar noted a normal spirometry with mild restriction of the total lung capacity, moderate diffusion impairment, and resting hypoxemia. As with his previous exam, Dr. Zaldivar noted that the miner had a low carboxyhemoglobin level consistent with that of a non-smoker. The lungs were clear on examination, with no wheezes, crackles, or rales. He concluded the following:

> Upon reviewing all of the records . . ., I find that Mr. Proffitt has had a slow drop of the diffusing capacity with time. At present, the diffusion impairment is quite marked. The lung markings at the bases have also increased in profusion. The spirometry has been well preserved; but, now, the total lung capacity has been reduced which was not so in the past.
>
> Another important finding currently present is the hypoxemia at rest which was never seen before.
>
> It is evident that Mr. Proffitt has slowly developed a diffusion impairment resulting from what clinically appears to be pulmonary fibrosis, both radiographically and by breathing tests, as well as by blood testing.

Dr. Zaldivar concluded that the miner suffered from pulmonary fibrosis unrelated to coal dust exposure for two main reasons. First, he noted that Claimant stopped working in the mines in the 1970s and subsequent ventilatory testing did not reveal any obstruction. He stated:

> Coal workers' pneumoconiosis, even if it were present, was not, and is not, causing any pulmonary impairment since coal workers' pneumoconiosis causes an obstructive impairment when it causes an impairment.

Second, Dr. Zaldivar noted that the miner demonstrated restriction on his testing along with a diffusion impairment:

> Such findings are typical of diseases which fall in the group of pulmonary fibrosis, such as bronchiolitis and pulmonary fibrosis, the most common of which is idiopathic.

Dr. Zaldivar concluded that the miner was totally disabled due, in part, to idiopathic pulmonary fibrosis.

Dr. Zaldivar was deposed for a second time in this claim on March 29, 2004. *Ex.* 12. He noted that a chest x-ray conducted during his 2002 examination of the miner revealed "some increased markings at the mid and lower zones, which may be due to pulmonary fibrosis." *Ex.* 12 at 12. Dr. Zaldivar opined that coal workers' pneumoconiosis usually starts in the upper lung zones and is "primarily nodular rather than linear." *Ex.* 12 at 12. He stated that the x-ray abnormalities appeared more irregular and seemed to "be more compatible with pulmonary fibrosis." *Ex.* 12 at 12. Moreover, he maintained that the "honeycombing" in the lungs represented "very advanced pulmonary fibrosis, and the bronchiectasis that was also read on the CT-scan." *Ex.* 12 at 22-23. He stated that coal dust induced fibrosis "does not cause honeycomb formation." *Ex.* 12 at 91. Dr. Zaldivar noted the following:

> Bronchiectasis has nothing to do with coal workers' pneumoconiosis. That, too, was shown by CAT scan. So there is absolutely nothing physiologically and nothing radiographically that resembles coal workers' pneumoconiosis regardless of how many years Mr. Proffitt worked in the coal mines.

Ex. 12 at 33. As previously noted, Dr. Zaldivar admitted that the Department of Labor "does not use race correction" on pulmonary function testing." *Ex.* 12 at 58.

Dr. Zaldivar further reported a "very abnormal" diffusion capacity that was not previously present. *Ex.* 12 at 18. He also noted reduced lung volumes, which supported a finding of a restrictive impairment. *Ex.* 12 at 18. Dr. Zaldivar agreed that the miner's pulmonary status had declined and, in particular, "the diffusion capacity ha[d] worsened considerably." *Ex.* 12 at 20. He also stated that Claimant's resting blood gas testing values were much lower and that the miner's pulmonary impairment had "progressed to the point where it is of clinical significance, and (the miner) is impaired at this time." *Ex.* 12 at 20-21. Dr. Zaldivar concluded:

> So we are dealing here with a progressive decrement of the forced vital capacity and the diffusion capacity which fits perfectly with a diagnosis of pulmonary fibrosis. There is absolutely no airway obstruction in this spirometry.
>
> . . .
>
> He is definitely worsening.

Ex. 12 at 84-85. Dr. Zaldivar testified that "the time will come when (Claimant) will be oxygen-dependent and then he will be short of breath with any activity at all, even speaking," which was

compatible with his diagnosis of idiopathic pulmonary fibrosis. *Ex.* 12 at 201. When asked about the onset of Claimant's pulmonary impairment, Dr. Zaldivar stated that "judging by the diffusing capacity, by (the) 1993 examination, there was a problem." *Ex.* 12 at 203.

Dr. Zaldivar noted that physiological abnormalities demonstrated during testing were compatible with idiopathic pulmonary fibrosis, which becomes more prevalent as a person ages. *Ex.* 12 at 23. He opined that "[s]imple coal workers' pneumoconiosis never causes a restrictive impairment" and it does not "cause a diffusion abnormality." *Ex.* 12 at 32.

Dr. Zaldivar acknowledged that silicosis can cause pulmonary fibrosis, but it is not pulmonary fibrosis by definition. *Ex.* 12 at 71. He stated that Claimant was "very likely" exposed to silica "to some extent" during his coal mining work. *Ex.* 12 at 75. However, Dr. Zaldivar maintained that Claimant did not have silicosis because "silica, number one, produces (sic) densities in the upper zones" and "[n]umber two, they are rounded preferentially just as coal workers' pneumoconiosis." *Ex.* 12 at 72. He further opined that silicosis causes obstruction and, at more advanced stages, restriction, "It does not cause diffuse interstitial fibrosis, which is what we are dealing with here." *Ex.* 12 at 81. Dr. Zaldivar asserted that it would be "faulty" to state that coal dust "goes into the lungs and causes fibrosis in (a) manner leading to a restrictive pulmonary impairment" because "the only fibrosis that will cause damage to the lungs from coal dust is the one produced by the aggregation of all these macules into large masses, which is a progressive massive fibrosis which is called so because it progresses with time." *Ex.* 12 at 214.

When asked about the concept of coal workers' pneumoconiosis causing a restrictive pulmonary impairment, Dr. Zaldivar responded that "such thing has not proven to be true." *Ex.* 12 at 215. Dr. Zaldivar opined that Claimant suffers from:

> . . . a progressive diffusing capacity impairment accompanied by radiographic changes typical of interstitial pulmonary fibrosis of the type, one of which is idiopathic pulmonary fibrosis which is not related to coal mining. It's a different entity entirely.
>
> The diffusing capacity abnormality which I just mentioned is mild and is not progressive. That's in coal workers.
>
> Mr. Proffitt has a disease entity all of his own, which is crippling. It has progressed with time and it is destroying his lungs, and it's interstitial fibrosis unrelated to coal mining.

Ex. 12 at 218. Dr. Zaldivar concluded that the miner's smoking history did not have a role in the development of his pulmonary fibrosis because he smoked one-half a pack per day until 1975 and his ventilatory testing did not reveal an obstruction. *Ex.* 12 at 94.

Dr. Zaldivar is board-certified in internal medicine, sleep disorders, critical care medicine, and pulmonary diseases. He is also a B-reader.

Dr. James H. Walker.

Dr. James H. Walker examined and tested the miner on behalf of the Department and issued a report on November 19, 1993. *Dx.* 114. He reported 32 years of coal mine employment and that the miner smoked 15 to 20 cigarettes per day from the age of 11 years until he quit in 1975. A chest x-ray was interpreted as revealing Category 0 pneumoconiosis. Blood gas testing was normal and pulmonary function testing demonstrated a minimal obstructive ventilatory defect. Examination of the lungs revealed "normal breath sounds." Claimant reported a productive cough and wheezing on a daily basis. The heart demonstrated a normal sinus rhythm and no palpable thrills. The heart sounds were of "good quality" with no murmurs, gallops, or friction rubs. Dr. Walker diagnosed coal workers' pneumoconiosis with an x-ray profusion of 0/1 as well as chronic bronchitis and bronchospasm. He concluded that the miner was not totally disabled.

Dr. Robert G. Loudon.

Dr. Robert G. Loudon conducted a review of certain medical records and issued an opinion on October 28, 1994. *Dx.* 133. He concluded that the miner did not suffer from coal workers' pneumoconiosis based "on the absence of x-ray evidence of pneumoconiosis or of compatible pulmonary function abnormalities." Dr. Loudon stated that the miner suffered from a "minimal degree" of smoking-induced chronic bronchitis that is "not sufficient to cause any pulmonary or respiratory impairment." He opined that Claimant may be disabled due to hypertension, heart disease, or obesity, but he is not totally disabled form a respiratory or pulmonary viewpoint.

During his April 25, 1995 deposition, Dr. Loudon testified that he is a "chest physician" and he focuses on "diseases of the lungs and of the respiratory system." *Dx.* 145 at 4. He stated that he has successfully passed the examination to become an A-reader. *Dx.* 145 at 17. For two years, Dr. Loudon worked at the Royal Infirmary in Edinburgh where he "would see a number of patients who had coal workers' pneumoconiosis" from working in nearby Scottish mines. *Dx.* 145 at 7-8.

Dr. Loudon defined "chronic bronchitis" as "the presence of a productive cough on most days for three consecutive months in each of two consecutive years and not resulting from other specific diseases such as tuberculosis or lung cancer." *Dx.* 145 at 32. He concluded that the miner did not suffer from clinical or legal coal workers' pneumoconiosis. *Dx.* 145 at 30 and 32. Rather, Dr. Loudon opined that Claimant "had a history of smoking sufficient to be related to his chronic bronchitis and to be considered its cause." *Dx.* 145 at 33.

He determined that the miner was totally disabled as a "whole person" due to his age, obesity, hypertension, diabetes, and possible orthopedic problems. *Dx.* 145 at 34. Dr. Loudon stated that the miner was not totally disabled from a respiratory standpoint because his pulmonary function, blood gas, and diffusing capacity studies yielded normal values. *Dx.* 145 at 35. Variability in the miner's test results militated against a finding of coal workers' pneumoconiosis, which is a fixed, permanent disease process. *Dx.* 145 at 36.

On March 11, 2004, Dr. Loudon issued a supplemental report based on his review of certain additional medical evidence. *Ex.* 10. He reiterated that there was not sufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis. Dr. Loudon stated that the miner suffered from a totally disabling pulmonary impairment that was unrelated to coal dust exposure. He concluded that his opinion would not change even if Claimant was found to suffer from pneumoconiosis. Dr. Loudon stated that the respiratory changes were "the result of lower lobe pulmonary fibrotic changes." He cited to the medical data upon which he relied, but offered no further explanation of his diagnosis in light of that data.

Dr. Loudon is a Professor of Medicine at the University of Cincinnati College of Medicine. He is a graduate of Medical School in Edinburgh Scotland and specializes in respiratory diseases.

Dr. Gregory Fino.

Dr. Gregory Fino reviewed certain medical records and issued a report on November 2, 1994. *Dx.* 133. He concluded that the miner does not suffer from a pulmonary condition arising out of coal dust exposure because: (1) a majority of chest x-rays are negative for the presence of the disease; (2) the "acceptable" ventilatory testing did not reveal restriction, obstruction, or any ventilatory impairment; (3) Claimant's lung volumes were normal and "[t]here is no over-distention or over-inflation consistent with an obstructive condition nor is there any evidence of under-inflation due to fibrosis of which pneumoconiosis is an example"; (4) "[t]here is no impairment in oxygen transfer as this man does not become hypoxic with exercise"; and (5) when corrected for his race, the miner's diffusing capacity is normal. Again, it is noted that Drs. Gaziano and Zaldivar correctly state that the Department of Labor does not recognize "race correction" for diffusing capacity values. Dr. Fino opined that the miner retained the respiratory ability to perform his last coal mining work as a general laborer, but he may be disabled as a result of age, hypertension, and diabetes.

By supplemental report dated November 15, 1994, Dr. Fino stated that, even if the presence of coal workers' pneumoconiosis was assumed, the miner was not disabled as a result of the disease because the miner's lung function testing did not reveal any abnormalities. *Dx.* 134.

Dr. Fino was deposed on April 27, 1995. *Dx.* 146. He noted that Claimant spent 22 years working in pre-1969 unregulated mines and ten years in post-1969 regulated mines. *Dx.* 146 at 10. Dr. Fino testified that coal mine induced lung disease would be present when Claimant ceased work and would not arise after cessation of his employment. *Dx.* 146 at 11. He opined the following:

> The normal course of an individual with pneumoconiosis is to leave the mines with that condition, and not worsen.

> The exception, that is when it can become progressive is limited to two different scenarios. Again, we are always talking about no further coal mine dust exposure following retirement.
>
> The first scenario is someone who has severe pulmonary fibrosis due to pneumoconiosis, we are talking category three pneumoconiosis, getting worse over time. That may occur.
>
> And the second scenario is someone who has a background of category 2 coal workers' pneumoconiosis, who is one of the few but nevertheless finite percent of individuals who progresses to complicated coal workers' pneumoconiosis.

Dx. 146 at 11-12.

Dr. Fino further stated that, unless a person suffers from category 2 or 3 pneumoconiosis when he leaves the mines, then he "should have no deterioration in his impairment" unless severe fibrosis or complicated pneumoconiosis is also present. *Dx.* 146 at 12. He noted that Claimant worked as a general laborer, which required "heavy and very heavy manual labor." *Dx.* 146 at 13.

Dr. Fino posited that the miner was smoking until 1990 and that a 40 year history of smoking one-half a pack of cigarettes per day would cause an obstructive lung impairment. *Dx.* 146 at 14. He noted that the miner's diffusing capacity and blood gas testing had "waxed and waned" over the years, which was contrary to a fixed, permanent condition such as coal workers' pneumoconiosis. *Dx.* 146 at 22. Dr. Fino concluded that the miner was totally disabled as a "whole man" due to his age alone, but he did not suffer from a respiratory disease arising out of coal mine employment. *Dx.* 146 at 28 and 31.

Dr. Fino reviewed certain additional medical records and issued supplemental reports on July 9 and 16, 1999. *Dx.* 194, 196. He reiterated that Claimant was "not disabled as a result of coal mine dust inhalation." He continued to note that the miner did not suffer from a pulmonary impairment.

Dr. Fino again reviewed certain medical records and issued a report on August 16, 2002. *Ex.* 3. He noted that Claimant stopped working in the mines in the 1970s and he exhibited no abnormality on ventilatory testing for 25 years, until Dr. Zaldivar's most recent testing. Dr. Fino further stated that the miner's lung volume studies and diffusing capacity results were normal in 1988, 1993, and 1995, but are reduced by the time of Dr. Zaldivar's 2002 examination. Dr. Fino opined the following:

> What really is seen in this individual is a reduction in the diffusion and lung volumes over time with preservation of the spirometric values. What has been developing is a restrictive type of abnormality. That can easily be explained in this case based on a CT-scan of the chest that was performed on April 2, 2001. Fibrosis was seen in the lower lobes more on the right than the left.

. . .

> (The miner) is developing diffuse interstitial fibrosis, which is a disease of the general medical population. This is not related to coal mine dust inhalation. Diffuse interstitial pulmonary fibrosis, when associated with coal mine dust (but not caused by coal mine dust) occurs along with obvious coal workers' pneumoconiosis. This man had no evidence of coal workers' pneumoconiosis or any respiratory impairment for over 20 years, since he was last employed.

Dr. Fino concludes that Claimant is totally disabled due to his lung disease, which is unrelated to coal dust exposure. He states that the miner does not suffer from clinical or legal coal workers' pneumoconiosis.

Dr. Fino reviewed certain additional medical records as well as treatment notes and issued supplemental opinions on March 10, 2004 and August 5, 2004. *Ex.* 10. He concluded the following:

> This man developed an idiopathic pulmonary fibrosis characterized by fibrotic scarring in the lower lung zones which accounts for the reduction in diffusing capacity and the hypoxemia noted in 2002. These changes are not consistent with a coal mine dust-related pulmonary condition.
>
> Although he is disabled due to lung disease, the disability is related to a non-occupational pulmonary condition. This man would be as disabled had he never stepped foot in the mines.

Dr. Fino further stated that he did not agree with Claimant's treating physician, Dr. Kennedy, that the miner suffered from "severe lung disease due to black lung syndrome."

Dr. Fino is board-certified in internal medicine and pulmonary diseases. He is also a B-reader.

Dr. Samuel V. Spagnolo.

Dr. Samuel V. Spagnolo reviewed certain medical records and issued a report on July 6, 1999. *Dx.* 193. He noted 32 years of coal mine employment, where the miner's last job required heavy manual labor. He also noted a 40 year history of smoking one pack of cigarettes per day. Dr. Spagnolo concluded that the miner did not suffer from coal workers' pneumoconiosis based on the examinations of Drs. Hayes, Jones, Egnor, Crisalli, Zaldivar, Walker, and Fritzhand. In particular, Dr. Spagnolo noted the following:

> (There were) negative physical examinations for evidence of interstitial lung disease and specifically the lack of any abnormal (rales, rhonchi, wheezes, crackles) lung sounds during physical examination, the pattern of chest x-ray findings, and the multiple normal tests of lung function.

Dr. Spagnolo stated that pulmonary function and blood gas testing revealed "no evidence of an obstructive or restrictive lung impairment." He concluded that Claimant did not suffer from a totally disabling pulmonary or respiratory condition.

Dr. Spagnolo reviewed certain additional x-ray interpretations and issued a supplemental report on July 14, 1999. *Dx.* 196. He noted that the chest x-ray interpretations were "widely variable," but the weight of the interpretations did not support a finding of coal workers' pneumoconiosis.

Again, Dr. Spagnolo reviewed certain additional medical records and issued a supplemental report on August 4, 2002. *Ex.* 2. He noted the presence of lower lobe fibrosis since 1995, which was "confirmed by the thoracic CT from April 2001." Dr. Spagnolo stated:

> It appears that Mr. Proffitt has developed a new lung condition unrelated to his prior coal dust exposure. In my opinion, the lower lobe disease is most likely related to chronic occult aspiration which has resulted in bronchiectasis and scarring.

Dr. Spagnolo noted that the condition was common in older individuals, but these changes would not prevent Claimant from performing his last coal mining job. He stated that a decrease in the miner's oxygen level during testing could "be secondary to either his increasing weight since 1975 or the development of bronchiectasis in the lower lung zones."

Dr. Spagnolo reviewed certain additional medical evidence and issued a supplemental report on March 12, 2004. *Ex.* 10. He noted clinical, physiologic, and radiographic findings of bronchiectasis involving multiple lobes of the miner's lungs:

> Bronchiectasis is a condition in which there is a permanent enlargement of medium-sized bronchi associated with cough and mucous production and this condition is a common cause of airflow obstruction.

Dr. Spagnolo opined that the condition is unrelated to coal dust exposure and it is sometimes mistaken for asthma or chronic obstructive pulmonary disease. He further noted that, in some individuals, bronchiectasis progresses and causes interstitial fibrosis. He stated that the miner does not suffer from a totally disabling respiratory impairment when his total lung capacity is adjusted for age, height, and race. Notably, Drs. Gaziano and Zaldivar correctly note that the Department of Labor does not recognize "race correction" for total lung capacity values. On the other hand, Dr. Spagnolo concludes that the miner is totally disabled due to advanced age, heart disease, diabetes, and arthritis.

Dr. Spagnolo reviewed the miner's treatment notes and issued a report on August 1, 2004. *Ex.* 11. He concluded that the notes demonstrate "findings consistent with hypertensive cardiac disease with concentric hypertrophy of the left ventricle." Dr. Spagnolo noted that there were no changes to his prior opinions.

Dr. Spagnolo serves as a Professor of Medicine at the George Washington University School of Medicine. He is also the Medical Director of the Respiratory Care Services for the Veterans Affairs Medical Center. He is board-certified in internal medicine and pulmonary diseases.

Treatment notes.

The record contains a series of treatment records from Dr. Chris Kennedy of Trident Cardiology Associates, P.A. *Cx.* 2; *Dx.* 215. On July 25, 2000, Dr. Kennedy noted a history of black lung, diabetes mellitus, and peripheral edema. He reported 32 years of coal mine employment and that the miner quit smoking in 1975. Examination of the chest was "surprisingly clear to auscultation bilaterally" with a "[m]ild increase in expiration phase noted." Cardiac examination revealed no murmurs, rubs, or gallops. Pulmonary function testing conducted by Dr. Miller demonstrated "normal mechanics and decreased diffusion capacity." Dr. Kennedy noted that Claimant complained of dyspnea on exertion and "[a]lthough a large part of his symptoms can be explained by his underlying pulmonary disease, cardiac component is certainly possible." Doppler testing revealed grossly normal LV systolic function, mild biatrial enlargement, and moderate pulmonary hypertension.

On August 4, 2000, it was noted that the miner's perfusion study yielded normal values with no evidence of ischemia. Office notes from Dr. Kennedy on August 17, 2000 demonstrate that the miner had "coarse crackles bilaterally" but his cardiac examination was normal. An EKG dated July 25, 2000 demonstrated normal excursion and no intra-cardiac masses or thrombus were observed. On June 6, 2003, an EKG produced mild to moderate left ventricular hypertrophy with normal left ventricular systolic function, mild aortic root dilation, and mild pulmonary hypertension. In notes dated February 16, 2004, Dr. Kennedy diagnosed severe lung disease due to black lung, diabetes, and hypertension. He noted that Claimant arrived for an office visit complaining of "chronic, severe dyspnea on exertion." Dr. Kennedy concluded that Claimant "really has no cardiac issues and it is unclear why he is here today." Examination of the lungs revealed "expiratory wheezing and mild rhonchi." Cardiac examination demonstrated normal S1 and S2 "with occasional ectopy." Dr. Kennedy opines that a primary cause of the miner's dyspnea on exertion is pulmonary, not cardiac.

Dr. Kennedy specializes in cardiology and cardiac catheterization.

Dr. K. Scott Miller, with Low Country Lung and Critical Care, P.A., is the miner's treating pulmonary physician. In his notes dated July 19, 2000, he referred Claimant to Dr. Kennedy for a cardiac evaluation. Pulmonary function testing revealed "normal mechanics and a

decreased diffusion." A chest x-ray was interpreted as positive for the presence of pneumoconiosis. Examination of the lungs revealed "soft, basilar crackles." Dr. Miller concluded that Claimant suffered from probable coal workers' pneumoconiosis.

Dr. Miller's office notes reflect that Claimant was initially referred to him on July 13, 2000 for the possible presence of black lung disease. *Cx.* 1. He reported a 32 year history of coal mine employment as well as a "probable" 50 pack year history of smoking, where the miner quit in 1975. Examination of the lungs revealed "clear" lung fields with a "few very soft, dry crackles at the left greater than right lung base." Dr. Miller further noted that "cardiac has an occasional ectopic beat, but without murmur, gallop, or rub." He concluded that Claimant "may have pneumoconiosis." Dr. Miller stated, however that the severity of the disease was unclear or "whether he has it" because "[h]is history is very nonspecific." A chest x-ray was conducted on July 19, 2000 and interpreted by Dr. Miller as revealing "chronic bibasilar fibrosis consistent with the patient's known history of interstitial lung disease."

In his September 21, 2000 notes, Dr. Miller states that the miner's dyspnea on exertion was due to black lung and deconditioning. He noted that chest x-rays revealed "stable, chronic, pulmonary fibrosis over the years." On November 21, 2000, Dr. Miller reiterated that Claimant suffered from "stable" lung disease. The chest was "quite quiet and clear" and the "cardiac is regular." On March 28, 2001, Dr. Miller stated that he was unable to explain Claimant's shortness of breath because the miner's "pulmonary mechanics (were) no different than they were 15 years ago" and his diffusing capacity was also unchanged.

On April 2, 2001, ventilatory testing demonstrated "some diminished ventilation at the lung bases." A Ventilation Perfusion Study revealed "some diminished perfusion at the lung bases bilaterally corresponding to the areas of diminished ventilation." By April 20, 2001, a chest x-ray demonstrated "increased interstitial markings at the lung base consistent with fibrosis" as well as "chronic bibasilar fibrosis consistent with the patient's known history of interstitial lung disease." On August 2, 2001, Claimant's daughter reported that the miner was doing well and "builds fences, cuts the grass, and . . . built a carport." Although Claimant asked to undergo a lung biopsy to assess his lung problem, Dr. Miller recommended against it. On November 15, 2002, Dr. Miller stated that, although the miner continue to complain "of marked shortness of breath, repeated pulmonary functions and x-rays have not shown any change really in his spirometry over the many years that we have seen him." Dr. Miller diagnosed stable black lung disease. Notes dated February 20, March 5, and July 14, 2004 continue to contain a diagnosis of "stable black lung disease" by Dr. Miller. Examinations of the lungs revealed crackles at the lung bases.

The April 2001 CT-scan.

A CT-scan was conducted on April 2, 2001 at the request of Dr. Miller. *Dx.* 221. Dr. Martha Anderson interpreted the test as revealing chronic fibrosis of the lower lobes. She observed no "ground glass" opacities and there was evidence of mild to moderate bronchiectasis in the upper and lower lobes.

The CT-scan was reviewed by Dr. Wiot who concluded, in a report dated June 8, 2001, that the study demonstrated interstitial fibrosis at the bases of the lungs with associated honeycombing. *Dx.* 221. He noted that "this distribution with sparing of the upper lung fields is totally against coal workers' pneumoconiosis."

In a report dated August 28, 2002, Dr. Wheeler concluded that no pneumoconiosis was present on the CT-scan, but there was minimal interstitial fibrosis "with few tiny cysts compatible with healed inflammatory disease with subtle right paraspinal pleural fibrosis." *Ex.* 6.

Dr. Scott also reviewed the CT-scan and, in a report dated August 29, 2002, he found "[m]oderate bronchiectasis and linear interstitial fibrosis with 'honeycombing' in the lower lungs, more in posterior portion of lungs." *Ex.* 6. He concluded that there was no evidence of silicosis or coal workers' pneumoconiosis.

Dr. Scatarige interpreted the CT-scan in a report dated August 30, 2002 and concluded that there was "minimal peripheral fibrosis" in the lower zones of both lungs as well as in the upper and middle zones of the right lung. *Ex.* 6. He stated that this was "compatible with usual interstitial pneumonitis," but that there was no evidence of silicosis or coal workers' pneumoconiosis.

Dr. Arthur L. Frank.

Dr. Arthur L. Frank reviewed certain medical records and issued an affidavit dated March 16, 2004. *Cx.* 5. Dr. Frank spent 11 years practicing medicine in Kentucky "and during that time was intimately involved with regular examinations of individuals working in the coal industry." Dr. Frank noted that Claimant has "demonstrated shortness of breath for many years, and has been found to have a reduced diffusing capacity and reduced exercise tolerance." He stated that the "most recent pulmonary function tests document a reduced lung volume and a significantly decreased diffusing capacity, all consistent with a restrictive lung disease such as coal workers' pneumoconiosis."

Dr. Frank was deposed on July 27, 2004. *Cx.* 3. Dr. Frank testified that the restrictive lung changes exhibited by Claimant on testing were consistent with a diagnosis of coal workers' pneumoconiosis. *Cx.* 3 at 35-36. He noted that exposure to coal dust can cause both restrictive and obstructive changes in the lungs and, in particular, it can cause restrictive changes when there is fibrosis. *Cx.* 3 at 27. Dr. Frank noted 32 years of coal mine employment, with the miner's last job as a roof bolter. *Cx.* 3 at 45-46. The miner's progressive shortness of breath was consistent with changes noted on the chest x-ray studies over time. *Cx.* 3 at 46. Dr. Frank testified:

> I think the most important thing is the regular finding of a decreased oxygenation in his blood, which speaks to a restrictive change. It goes along with scarring we see on his lungs and some of the other changes that are there.

Cx. 3 at 48. In explaining the significance of a reduced diffusion capacity, Dr. Frank stated:

> That means he doesn't move oxygen from the alveoli, the little air sacs, into his blood stream in a normal fashion. The most common cause of reduction are changes, and in people like Mr. Proffitt, they are fibrosis that he has. And the fibrosis again, in my opinion, was caused by his exposure to coal dust.

Cx. 3 at 49-50.

Dr. Frank also acknowledged the presence of Claimant's history of smoking cigarettes and stated the following:

> It should be noted that Mr. Proffitt stopped smoking almost 30 years ago and his lung disease has gotten worse.
>
> Once you give up smoking, if you have done damage to your lungs, it generally doesn't get better. It only gets better a little bit. A lot of his problems have gotten significantly worse since then and wouldn't have been something that you would relate to his very distant past smoking history.

Cx. 3 at 52. Dr. Frank diagnosed the presence of coal workers' pneumoconiosis based on "history, physical findings, the pulmonary function findings and importantly to me the x-ray findings with rounded opacities . . .." *Cx.* 3 at 53. He noted that it was "a little unusual" for the opacities to begin at the bottom of the lungs and work their way to the top of the lungs, but he had "seen other cases of that as well." *Cx.* 3 at 70. Dr. Frank agreed with Dr. Zaldivar's 2002 report that Claimant demonstrated pulmonary fibrosis and the CT-scan evidence of "honeycombing" was consistent with coal workers' pneumoconiosis at advanced stages. *Cx.* 3 at 108.

Dr. Frank further stated that Claimant is totally disabled due, at least in part, to coal workers' pneumoconiosis. *Cx.* 3 at 54. The most recent pulmonary function testing revealed restriction and a reduced diffusing capacity. *Cx.* 3 at 86.

Dr. Frank is a Professor of Public Health with the Department of Environmental and Occupational Health at the Drexel University School of Public Health. He is also a Professor of Medicine at the Drexel School of Medicine and a Clinical Professor at the Department of Medicine with the University of North Texas Health Service Center. Dr. Frank is an adjunct faculty member for the U.S. Air Force School of Aerospace Medicine. He served as a member of the NIOSH Study Section for Occupational Safety and Health from 1985 to 1988 and he chaired the section from 1988-89. He was also a member of the NIOSH Board of Scientific Counselors from 1992 to 1996. Dr. Frank has a doctoral degree in Biomedical Sciences and is board-certified in internal medicine and occupational medicine.

Discussion and Conclusions Regarding Medical Opinion Evidence

Since it is Employer's burden to establish rebuttal under subsection (b)(4), each of the reasons underlying its physicians' reports in support of rebuttal will be discussed. Initially, greatest weight will be accorded the opinions based on more recent examinations and testing of the miner because they contain a more accurate evaluation of the miner's current, deteriorating condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). Therefore, the undersigned will focus on the opinions of Drs. Frank, Crisalli, Zaldivar, Loudon, Fino, and Spagnolo generated in 2002 and thereafter as these opinions post-date other opinions of record by four to 27 years and contain a more accurate assessment of the miner's current condition. *See Gillespie, supra*.

Of these physicians, it is determined that Dr. Loudon's March 2004 opinion is devoid of adequate reasoning in support of his conclusion that Claimant does not suffer from coal workers' pneumoconiosis. Indeed, Dr. Loudon merely notes that there is insufficient objective medical data to support a finding of the disease and that, even if the disease was present, it did not contribute to the miner's totally disabling respiratory impairment. Without further explanation, Dr. Loudon's opinion regarding the cause of Claimant's totally disabling respiratory impairment is not persuasive and will not be discussed further. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984) (a physician's opinion is not probative where the basis for the opinion cannot be determined); *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc) (an unreasoned or undocumented report may be accorded little weight).

Diagnosis of bronchiectasis

Dr. Spagnolo concludes that the lower lobe fibrosis observed on chest x-rays and CT-scan of the miner was "most likely related to chronic occult aspiration which has resulted in bronchiectasis and scarring." He then states that "[b]ronchiectasis is a condition in which there is a permanent enlargement of medium-sized bronchi associated with cough and mucous production and this condition is a common cause of airflow obstruction." Indeed, Dr. Spagnolo concluded that bronchiectasis is often misdiagnosed as chronic obstructive pulmonary disease or asthma. Dr. Spagnolo notes that, as the disease progresses, it may result in interstitial fibrosis. The uncontradicted medical evidence in this record, however, establishes that the miner suffers from a *purely restrictive impairment*—there is no obstruction based on the examinations and testing of numerous physicians. Dr. Spagnolo has failed to explain the inconsistency between his diagnosis and the underlying medical data upon which he relies. As a result, his opinion is unreasoned and undocumented and is accorded little probative value. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986) (a report may be accorded little weight where it is internally inconsistent and inadequately reasoned); *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984) (an unsupported medical conclusion is not a reasoned diagnosis); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his diagnosis). Likewise, the opinions of Drs. Crisalli, Zaldivar, Anderson, and Scott, that the progressing fibrosis is caused in part by bronchiectasis, are undocumented and unreasoned.

Restrictive impairment

Drs. Crisalli and Zaldivar reason that the miner's progressive fibrosis is not coal dust related because testing revealed a purely restrictive impairment and reduced diffusing capacity without any evidence of obstruction. Dr. Crisalli opined that coal workers' pneumoconiosis usually causes an obstructive impairment. Likewise, Dr. Zaldivar testified that "[s]imple coal workers' pneumoconiosis never causes a restrictive impairment" and it does not "cause a diffusion abnormality."[3] This is contrary to Dr. Fino's position who, in his 1994 report, stated that the miner did not suffer from coal-dust-related pulmonary impairment because there was no "evidence of under-inflation due to fibrosis of which pneumoconiosis is an example. . . ." At the time Dr. Fino issued the 1994 report, Claimant's lung condition had not progressed to the point of manifesting a restriction. However, it is evident from the text of his 1994 report that Dr. Fino believed that pneumoconiosis typically causes a restrictive impairment. This is consistent with Dr. Frank's view as he reasonably opines that coal workers' pneumoconiosis may cause restrictive changes in the miner's lungs, particularly where there is fibrosis and resulting scarring as documented on this record. Dr. Frank further stated that the reduced diffusing capacity, which demonstrates decreased oxygenation, is consistent with the fibrosis and restrictive impairment noted on the miner's objective testing and, taken as a whole, these findings are consistent with the presence of a coal dust induced respiratory impairment. Dr. Frank's opinion is the most persuasive as it is consistent with the objective medical data and well-reasoned.

Interstitial fibrosis in a "honeycombing" pattern and commencing in the lower lungs

Drs. Crisalli, Zaldivar, and Fino opine that the development of an (1) interstitial fibrosis, (2) starting in the lower lungs, and (3) forming a "honeycomb" pattern, is inconsistent with coal workers' pneumoconiosis. They state, *inter alia*, that pneumoconiosis did not cause Claimant's "interstitial fibrosis" as it does not start in the lower lungs or form a "honeycomb" pattern unless, according to Dr. Zaldivar, the disease is advanced. Dr. Crisalli notes that the chest x-ray and CT-scan evidence demonstrates an interstitial pulmonary fibrosis process, which is not expected of a person suffering from coal workers' pneumoconiosis. Importantly, Dr. Zaldivar concedes that exposure to silicosis can contribute to the development of pulmonary fibrosis and that Claimant was "very likely" exposed to silica during his coal mine employment history. He opined that silica exposure did not cause the development of pulmonary fibrosis in this case because the densities on x-ray were mostly in the lower lung zones and they were not rounded. Dr. Frank persuasively explains that, when diagnosing a lung condition such as that suffered by the miner in this case, it is critical to take the miner's history into account and the fact that the disease has started in the lower lung zones, formed a "honeycomb" pattern, or is linear or irregular does not preclude a finding of a coal dust induced respiratory impairment when considering the medical data as a whole.

[3] It is interesting that, in Stover v. Consolidation Coal Co., 45 F.3d 427 (4th Cir. 1995), Dr. Zaldivar took a different position to state that the miner that case did not suffer from a coal dust induced respiratory impairment partly because "pulmonary function studies reflected the presence of an obstructive form of respiratory impairment rather than the restrictive form associated with pneumoconiosis."

In this vein, Dr. Frank states that, while it is "unusual" for coal workers' pneumoconiosis to begin in the lower lungs, he had "seen other cases of that as well." Moreover, he agreed with Dr. Zaldivar that coal workers' pneumoconiosis, in its advanced stages, can produce a "honeycombing" pattern in the lungs. Dr. Frank's persuasively opines that the honeycombing pattern and the fact that the fibrosis commenced in the lower lungs do not preclude a finding that coal dust and/or silica exposure contributed to development of the miner's fibrosis, particularly in light of Dr. Frank's reasonable position that a patient's social, work, and exposure histories play in important role in determining the cause of any ailment. Here, Dr. Frank notes that the miner had 32 years of exposure to coal dust, with nearly 20 years of such exposure occurring prior to enactment of the Act in 1969, which set forth the first comprehensive health and safety standards for the mining industry. During this time, it is undisputed that Claimant worked as a general laborer and was exposed to significant coal and/or silica dust. None of the physicians notes any other significant exposure history. Although all of the physicians noted that the miner smoked cigarettes at one time, none of them concludes that this history contributed to the development of his fibrosis given the fact that the resulting impairment is purely restrictive. Because of his significant level of coal dust exposure, with no other exposure history reported in any of the medical records, and the fact that the miner's fibrosis is progressive and has produced a restrictive impairment, Dr. Frank concludes that it is most reasonable to attribute the cause of the fibrosis to the miner's extensive coal dust and/or silica exposure despite the fact that the densities started in the miner's lower lungs, have developed into a "honeycomb" pattern, and are generally linear. Again, Dr. Frank's opinion reasonably addresses the objective medical data of record and is well-reasoned.

Latent and progressive

Dr. Crisalli maintains that Claimant's pulmonary fibrosis was not due to coal dust exposure because 16 years elapsed between the time Claimant left the mines and the time the fibrosis was manifest on objective testing. Dr. Crisalli opines that there "isn't a latent period for coal workers' pneumoconiosis like there is for asbestosis." Similarly, Dr. Zaldivar declined to diagnose a coal dust induced respiratory impairment because Claimant stopped working in the mines in the 1970s and subsequent ventilatory testing did not reveal any obstruction. Dr. Fino testified that coal workers' pneumoconiosis should be present when Claimant ceases work and would not arise after leaving the mines. He asserted that pneumoconiosis is "progressive" only in the case of "severe pulmonary fibrosis due to pneumoconiosis" or a miner with a background of category 2 coal workers' pneumoconiosis when he leaves the mines.

Although the definition of "pneumoconiosis" at 20 C.F.R. § 727.202 is controlling in this case, it is proper to consider the Department's position on "pneumoconiosis" as a medical and legal concept during recent rulemaking for the amended regulations at 20 C.F.R. Part 718 (2001). Notably, during the rulemaking proceedings, the Department received similar comments from medical experts regarding latency and rejected the comments as not in accord with the prevailing view of the medical community. In particular, the Department cited to studies supporting a finding the pneumoconiosis may develop even after a person has left the mines with no x-ray or other evidence of simple pneumoconiosis at the time. 65 Fed. Reg. 79970 (Dec. 20, 2000). Further, the Department noted that there is medical data that "lung function can continue to

deteriorate after a miner leaves the coal mining industry." 65 Fed. Reg. 79971 (Dec. 20, 2000). The Department concluded that "it is clear that a miner who may be asymptomatic and without significant impairment at retirement can develop a significant impairment after a latent period." 65 Fed. Reg. 79971 (Dec. 20, 2000). This comports with the Fourth Circuit's long-held view. In *Barnes v. Mathews*, 562 F.2d 278, 279 (4th Cir. 1977), the circuit court noted that "neumoconiosis is a slow, progressive disease often difficult to diagnose at early stages." In this case, Dr. Frank concludes that the miner's lung impairment is coal dust related despite the fact that the disease was not diagnosed, and did not produce an impairment, until many years after his retirement. It is evident that the fibrosis developing in the miner's lungs is progressive and irreversible, which is consistent with a disease process arising out of coal dust exposure.

Qualifications of the experts

Finally, the qualifications of the physicians must be considered when weighing their medical opinions. Drs. Crisalli, Zaldivar, Fino, and Spagnolo are board-certified in internal medicine and pulmonary diseases. Dr. Zaldivar also has board-certification in critical care medicine and sleep disorders. Drs. Spagnolo, Loudon, and Crisalli are also professors of medicine at various universities.

Dr. Frank is board-certified in internal medicine and occupational diseases. Further, he is a professor of medicine. Dr. Frank also has a doctorate in Biomedical Sciences. Notably, when compared to the other physicians of record, Dr. Frank had 11 years of extensive experience regularly conducting examinations of miners in Kentucky. He served as a member of a NIOSH Study Section for Occupational Safety and Health from 1985 to 1998 and chaired the section from 1988 to 1989. Further, Dr. Frank was a member of the NIOSH Board of Scientific Counselors from 1992 to 1996. Dr. Frank's extensive educational background combined with his considerable involvement with NIOSH and practical experience in examining and treating coal miners leads the undersigned to find that Dr. Frank has superior qualifications on this record. Therefore, it is determined that Dr. Frank's medical opinion is accorded greater weight due, in part, to his superior qualifications.

Conclusion-Subsection (B)(4) Rebuttal Not Established

In sum, Employer has not presented medical evidence sufficient to demonstrate subsection (b)(4) rebuttal. Claimant was employed as a general laborer in underground mining for 31 years—nearly 20 years of which was spent working in coal mines prior to the 1969 enactment of the Act. Although the chest x-ray evidence did not support a finding of Category 1 pneumoconiosis, dually-qualified physicians did note the presence of increasing fibrosis. Dr Wiot determined on his chest x-ray interpretations that the fibrosis could not be coal dust related because it began in the lower lungs.

In recent medical opinions, the physicians agree that Claimant suffers from disabling, progressive pulmonary fibrosis. Dr. Zaldivar notes that (1) silicosis can cause pulmonary fibrosis, and (2) it is "very likely" that Claimant was exposed to silica during his employment in the mines. However, Dr. Zaldivar as well as Drs. Spagnolo and Crisalli conclude that the pulmonary fibrosis is not caused by coal mine employment because it resulted in a purely

restrictive impairment and reduced diffusing capacity, there were negative chest x-ray findings, and the miner's fibrosis developed a honeycombing pattern in the miner's lower lungs and was linear and irregularly shaped. As a result, they concluded that the cause of the miner's fibrosis was unknown. Dr. Fino agreed with Drs. Zaldivar, Spagnolo, and Crisalli except Dr. Fino opined that pneumoconiosis would typically cause a restrictive impairment.

Based on Dr. Frank's excellent credentials, including his experience examining and treating coal miners, and the well-reasoned and well-documented opinions he prepared in this matter, it is determined that coal dust and/or silica exposure contributed to the development of Claimant's disabling pulmonary fibrosis. Dr. Frank reasonably states that, in his experience, he has seen cases of miners whose coal workers' pneumoconiosis began in the lower lungs. Moreover, he persuasively notes that the disease may form a honeycombing pattern and may be linear. Importantly, Dr. Frank opines that miner's fibrosis carries many qualities that are highly consistent with coal workers' pneumoconiosis; namely, the disease is progressive and irreversible and has produced a restrictive impairment and reduced diffusing capacity. Moreover, Dr. Frank notes, consistent with the Department's view, that pneumoconiosis may manifest itself and become disabling after a latent period. Dr. Frank reasonably stressed the importance of the miner's significant exposure history when rendering a diagnosis. He persuasively maintains that the characteristics of Claimant's lung disease are sufficiently consistent with those expected of a coal dust induced lung disease that, given the miner's 32 years of exposure to coal dust and/or silica with no other exposure history noted in any of the medical records, it is most reasonable to attribute the lung impairment to such exposure as opposed to stating that its cause is unknown. Dr. Frank's opinion is further supported by the miner's current treatment records.

Based upon the foregoing, I find that the Employer has not established rebuttal under §727.203(b)(4) by a preponderance of the chest x-ray and medical opinion evidence.

Subsection (B)(3) Rebuttal

Having determined that Claimant suffers from pneumoconiosis and, based on Employer's concession that the miner has a totally disabling respiratory impairment, it is Employer's burden to submit medical evidence sufficient to "rule out" the causal relationship between the miner's total disability and pneumoconiosis. 20 C.F.R. § 727.203(b)(3); *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 137 F.3d 799 (4th Cir. 1998). *See also Borgenson v. Kaiser Steel Corp.*, 12 B.L.R. 1-169 (1989) (*en banc*).

Here, all of the physicians who submitted recent medical opinions agree that the miner's pulmonary fibrosis is totally disabling. For reasons previously addressed, Drs. Fino, Crisalli, Zaldivar, Loudon, and Spagnolo concluded that the cause of Claimant's fibrosis was unknown. Dr. Frank, on the other hand, opined that it was caused, in part, by coal dust exposure. Based on the foregoing discussion regarding subsection (b)(4) rebuttal, I find that Dr. Frank's opinion, that the miner's disabling fibrosis is due in part to his coal dust exposure, is the most well-reasoned and well-documented. As a result, I find that Employer has not established rebuttal under §727.203(b)(3) of the regulations.

Date of Entitlement

The amended regulations at 20 C.F.R. §725.503(d) (2001) codify case law related to determining onset dates in claims involving modification petitions:

> (d) If a claim is awarded pursuant to section 22 of the Longshore Act and §725.310, then the date from which benefits are payable shall be determined as follows:
>
> > (1) Mistake in fact. The provisions of paragraphs (b) or (c) of this section, as applicable, shall govern the determination of the date from which benefits are payable.
> >
> > (2) Change in conditions. Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month in which the claimant requested modification.

20 C.F.R. §725.303(d) (2001).

In this case, there is no evidence of a mistake in a determination of fact. Instead, the Claimant has established a change in conditions by establishing that he has now progressed to total pulmonary disability. However, I find that the exact month of onset of his disability cannot be determined. Therefore, I find that benefits are payable from the month in which the Claimant requested modification, November 2000.[4]

ORDER

Accordingly, it is Ordered that:

1. The Employer, Valley Camp Coal Company, shall pay to the Claimant, Chilion Proffit, all benefits to which he is entitled under the Act, commencing November 1, 2000;

2. The Employer shall pay for or otherwise provide all medical benefits to which Claimant is entitled;

[4] The Benefits Review Board Acknowledged the Claimant appeal of the October 24, 2000, decision denying modification by Judge Holmes on November 30, 2000. At the same time, the Board also acknowledged receipt of new evidence submitted by the Claimant as a request for modification, and remanded the claim for modification. (DX 216, 219).

3. The benefits paid hereunder shall be offset by virtue of any state awards to the Claimant for workers' compensation for occupational disease; and

4. Claimant's attorney, within 20 days of receipt of this order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

A

RICHARD E. HUDDLESTON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.